Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 13, 2022

Mr. Christopher Martin, Administrator
Cedar Hill Health Care Center
49 Cedar Hill Drive
Windsor, VT 05089-9470

Dear Mr. Martin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 20, 2022.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475046	A. BUILDING _____ B. WING _____	04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR HILL HEALTH CARE CENTER	49 CEDAR HILL DRIVE WINDSOR, VT 05089

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E 000	Initial Comments The Division of Licensing and Protection conducted an unannounced emergency preparedness survey from 04/18/22 through 04/20/22. There were no regulatory violations identified related to emergency preparedness.	E 000	This plan of correction is in response to alleged deficiencies that are cited in the CMS-2567from the annual survey that was conducted April 18-20, 2022.	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and staff vaccination requirement review were conducted from 04/18/22 through 04/20/22 by the Division of Licensing and Protection. The following regulatory violations were identified:	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583	Cedar Hill continues to ensure that the residents' rights to privacy and confidentiality are being met. 1. Actions taken for residents affected by the alleged deficient practice: The documents that had confidential resident information were immediately removed or turned over, to provide privacy to the residents' health information. 2. Identification of others who may be affected by the alleged deficient practice: The DON or designee will walk through and document observations of every resident's bedroom and bathroom to ensure compliance with the residents' rights to privacy and confidentiality. 3. Systems and measures to ensure that the alleged deficient practice does not recur: The sign-in document was removed from use. An in-service will be held for all staff in the nursing department to provide	4/20/2022 5/10/2022 6/4/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindy Martin		5/13/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that resident personal and medical information was maintained in a secure and confidential manner, so that others would not have access to it for 1 of 19 sampled residents and 1 of 2 medication carts with identifying information for all residents. Findings include: 1. Per observation on 4/20/2022 at 2:11 PM a sign was posted on the outside of the door, toward the hallway of room 16 that stated: "Infection Prevention and Control Policy for Suspected or Confirmed Coronavirus (COVID 19); Room log: Residents with suspected or confirmed Coronavirus (COVID 19); Residents name: [The resident's name was written in]; Employee or Visitor Name: Date: Time In: Time Out:" An employee had signed in on 4/19/22 at 7:20 AM and 9:30 AM. This sign in sheet was located on the door next to a sign that stated "STOP: Modified DROPLET PRECAUTIONS. Visitors MUST report to Nursing Station before	F 583	facility guidelines for HIPAA and residents' right to privacy and confidentiality by 6/4/22. 4. Monitoring compliance of the alleged deficient practice: An Infection Preventionist will ensure that rooms are set up properly when a resident is placed on precautions, and without any private or confidential information being sharedin the hallway. Med pass audits will be done twice a quarter, which will include resident confidentiality. This will be done by the staff educator and the pharmacy consultant. These findings will be reported and discussed in QAPI quarterly. **TAG F 583 POC Accepted on 5/13/22 by G. Mercure/P. Cota**	6/4/2022

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F 583	Continued From page 2 entering. visitors and staff must: Wear a mask Wear eye protection (goggles or face shield) when entering room" On 4/20/22 at 3:09 PM when asked about the signs and documentation, the Director of Nursing (DNS) stated that the sign in sheet should not be on the door as it is not necessary for staff to sign in and out of the room. The DNS confirmed that the resident's name should not be posted on the sign in sheet for others to see, which discloses a potential health condition. 2. Observation on 4/20/22 10:50 AM - 11:03 AM revealed an unlocked medication cart, and upon the medication cart was noted a "24 hour report" that included resident names, and room numbers. A computer that was on top of the medication cart was left open at a the "Clinical" and "Current" residents screen. It showed a list of resident names and room numbers - this allowed access to all residents medical records. The nurse was observed behind a tall wall in the nurses station that separated the nurses station from the medication carts and prohibited a constant visual of the medication cart. Upon the nurses return to the medication cart at 11:03 AM, s/he immediately locked the medication cart, closed out of the patient care records screen on the computer and, turned over the 24 hour report sheet so the information on that sheet was not upright and available for others to see. Interview with the nurse at 11:04 AM, confirmed that the medication cart should not have been left	F 583		

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F 583	Continued From page 3 unlocked, and all resident information should not have left out in the open for anyone passing by or standing at the medication cart to have easy access to.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584	Cedar Hill continues to maintain a safe, clean, comfortable and homelike environment. 1. Actions taken for residents affected by the alleged deficient practice: The bathroom between rooms 9 and 10 was cleaned immediately on 4/19/2022 when the issue was brought to the environmental manager. 2. Identification of others who may be affected by the alleged deficient practice: All residents' bathrooms were observed and inspected by the administrator and owner on 4/19/2022 with follow through as needed. 3. Systems and measures to ensure that the alleged deficient practice does not recur: Each hallway will have wipes available for staff to clean as they arise. These disinfectant wipes will be kept out of reach of residents. Staff will be provided with education about new availability of cleaning material for staff to use, as well as need to clean up areas at all times during the day/night. 4. Monitoring compliance of the alleged deficient practice: Daily bathroom and room checks will be monitored weekly by administrator or designee. Results of this audit will be brought to QAPI.	4/19/2022 4/19/2022 6/4/2022 6/4/2022

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F 584	Continued From page 4 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary environment, specifically in one shared resident bathroom for 2 of 22 resident rooms. Findings include: During unit observations on 4/18/2022 at 11:45 AM and 3:30 PM, in the bathroom located between rooms 9 and 10 there was dried splattered feces on the wall next to the toilet. This was observed again the next day, on 4/19/2022 at 2:24 PM. On 4/19/2022 at 2:24 PM the Environmental Manager (EM) was shown the feces on the wall next to the toilet. The EM stated "Okay, the housekeeper has not been in here today because the residents were in and out of the bathroom all day. As you can see the trash is full and has not been emptied." When told that the feces had been there the prior day s/he stated "I will get [her/him] in here now to clean this."	F 584	**TAG F 584 POC Accepted on 5/13/22 by G. Mercure/P. Cota**	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		

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F 657	Continued From page 5 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the plan of care for 2 of 19 sampled residents in a standard survey sample were revised to reflect necessary care and services. (Residents #9, and #15). Findings include: 1. Observation on 4/18/2022 at 11:50 am, Resident #9 was sitting in the common area in a wheelchair without footrests. A licensed nursing	F 657	Cedar Hill ensures that residents have comprehensive care plans that are revised to reflect necessary care and services. 1. Actions taken for residents affected by the alleged deficient practice: Residents #9 and #15's mobility care plans will be reviewed and updated to reflect the need for footrests on their wheelchairs and frequency of use. The "Physical Mobility Sheets" will be updated for these two residents as well. This information will be added to the LNA assignment sheets. 2. Identification of others who may be affected by the alleged deficient practice: All mobility care plans will be reviewed and updated, if needed. An audit will be performed to ensure each resident that uses a wheelchair that has a set of footrests to use as needed. All nursing and recreation staff will attend an in-service for education on these changes to the procedure on how and when to use foot rests with wheelchairs. 3. Systems and measures to ensure that the alleged deficient practice does not recur: It will be added to the nursing admission checklist as a reminder to ensure that footrest use is added to the mobility worksheet on admission. This will also be added to the care plan templates in PCC so it can be readily added to care plans.	5/10/2022 6/4/2022 6/4/2022

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F 657	Continued From page 6 assistant (LNA) asked her/him to pick up her/his feet and began to push the resident to the dining room. The resident did lift her/his feet up while the LNA pushed her/him to the dining room although she/he did put her/his feet down a few times during the transport. Observation on 4/18/22 at 11:52 AM, revealed a pair of wheelchair foot pedals on top of Resident #9's dresser in her/his room. Review of Resident #9's care plan revealed, ".....has limited physical mobility r/t [related to] Parkinson's Disease, dementia and a non-repaired left hip fracture" with the following intervention "Resident needs assistance with moving [pronoun omitted] scoot w/c [wheelchair] but can also self-propel short distances." Per interview on 4/20/2022 at 10:34 AM, a licensed practical nurse (LPN) stated that foot pedals are in the resident's room. The LPN explained that staff know when to use foot pedals by referring to the sheet on the resident's closet door (Physical Mobility Sheet) and the resident's care plan. Reviewed of Resident #9's Physical Mobility Sheet with the LPN, s/he confirmed the "I" on Resident's Physical Mobility sheet indicated that the resident was independent in her/his wheelchair. There was no direction indicated on the Physical Mobility Sheet explaining when to use foot pedals. Upon review of Resident #9's care plan with this LPN, s/he confirmed that the care plan does not direct staff when to use foot pedals. Interview on 4/20/2022 at 10:55 AM, a licensed nurse aid (LNA) stated that each resident has a mobility sheet on the inside of their closet door that's shows when to use wheelchair foot pedals.	F 657	4. Monitoring compliance of the alleged deficient practice: The care plans are reviewed quarterly and with any changes. In addition, the "Physical Mobility Sheets" will also be audited and reviewed quarterly. This progress will be reported and discussed in QAPI. **TAG F 657 POC Accepted on 5/13/22 by G. Mercure/P. Cota**	5/10/2022

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F 657	Continued From page 7 S/he would put foot pedals on the wheelchair while bringing a resident for a walk outside, if their feet/legs are swelling, or they can't keep their feet up. Some foot pedals would be considered a restraint. The LNA confirmed that the use of foot pedals would also be in the care plan. On 4/20/2022 at 11:40 AM during an interview with the Director of Nursing, she/he confirmed the use of foot pedals should be on the care plan and that Resident #9's care plan did not provide direction as to when staff would need to use the residents foot pedals. S/he stated that Resident #9's care plan needed to be updated to include when to use foot pedals. The DON also confirmed that the use of foot pedals should be listed on the "Physical Mobility Sheet", which is on the inside of the residents closet door and on each residents care plan. Review of Resident #9's "Physical Mobility Sheet" revealed no indication for use of his/her foot pedals and there was no mention of foot pedals on the residents care plan. 2. Per observation on 4/18/2022 at 11:52 am, Resident #15 was sitting in the common area in a wheelchair without footrests. A licensed nursing assistant (LNA) asked him/her to pick up his/her feet and began to push the resident to the dining room. The resident lifted his/her feet approximately an inch off the ground for a couple seconds and then began to drag his/her feet while being pushed down the hall. Review of Resident #15's medical record lists history of falling, muscle weakness (generalized), and other abnormalities of gait and mobility as	F 657		

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F 657	Continued From page 8	F 657		

diagnoses. Per review of Resident #15's care plan revealed, "the resident is able to complete wheelchair mobility for short distances independently, dependent on staff for purposeful movement and requires vocal cues to lift feet when staff are assisting with WC [wheelchair] mobility." Per review of ADL (Activities of Daily Living) documentation for the month of April, of the 68 instances of locomotion documented for Resident #15, 50 were "extensive assistance" or "total dependence."

Per observation on 4/19/2022 at 11:36 AM, Resident #15 was seen sitting in his/her wheelchair and was being pushed to the dining room by a staff member. It was noted that his/her feet were dragging on the floor while being pushed down the hall to the dining room.

Per interview on 4/20/2022 at 10:34 AM, a licensed practical nurse (LPN) stated that foot pedals are in the Resident's room. The LPN explained that staff know when to use foot pedals by referring to the sheet on the resident's closet door (Physical Mobility Sheet) and the resident's care plan. Reviewed of Resident #15's Physical Mobility Sheet with the LPN, s/he confirmed the "I" on Resident #15's Physical Mobility sheet indicated that the resident was independent in his/her wheelchair, and it did not explain when to use foot pedals. Upon review of Resident #15's care plan with this LPN, s/he confirmed that the care plan does not direct staff when to use foot pedals.

Per interview on 4/20/2022 at 10:55 AM, a LNA stated that each resident has a mobility sheet on the inside of their closet door that's shows when to use wheelchair foot pedals. S/he would put foot

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F 657	Continued From page 9 pedals on the wheelchair while bringing a resident for a walk outside, if their feet/legs are swelling, or they can't keep their feet up. Some foot pedals would be considered a restraint. The LNA confirmed that the use of foot pedals would also be in the care plan. On 4/20/2022 at 11:40 AM during an interview with the Director of Nursing (DON), he/she confirmed the use of foot pedals should be on the care plan and that Resident #15's care plan did not provide direction as to when staff would need to use the residents foot pedals. S/he stated that Resident #15's care plan needed to be updated to include when to use foot pedals.	F 657		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761	Cedar Hill continues to store medications as the regulation outlines. 1. Actions taken for residents affected by the alleged deficient practice: There were no residents affected by this alleged deficient practice. The medications did not leave the medication cart. 2. Identification of others who may be affected by the alleged deficient practice: All nurses will be re-educated about when to lock carts. 3. Systems and measures to ensure that the alleged deficient practice does not recur: Med pass audits will be completed once a quarter by consultant pharmacy. Nurse managers will check compliance with medication cart lock weekly and report results to QA.	5/13/2022 6/4/2022

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F 761	Continued From page 10 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure drugs and biologicals are stored in accordance with accepted professional standards for 1 of 2 medication carts. Findings include: Observation on 4/20/22 10:50 AM - 11:03 AM revealed an unlocked medication cart. The nurse was observed behind a tall wall in the nurses station that separated the nurses station from the medication carts and prohibited a constant visual of the medication cart. Upon the nurses return to the medication cart at 11:03 AM, s/he immediately locked the medication cart.	F 761	4. Monitoring compliance of the alleged deficient practice: The findings from the med pass audits will be reported and discussed in QAPI. **TAG F 761 POC Accepted on 5/13/22 by G. Mercure/P. Cota**	6/4/2022